

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005075	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/18/2013
NAME OF PROVIDER OR SUPPLIER ST VINCENT HOSPITAL & HEALTH SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 2001 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for a State hospital complaint investigation.</p> <p>Complaint: #IN00120209 Unsubstantiated; lack of sufficient evidence</p> <p>Survey Date: 10/18/13</p> <p>Facility #: 005075</p> <p>Surveyor: Linda Dubak, R.N. Public Health Nurse Surveyor</p> <p>St. Vincent Hospital and Health Services is in compliance with 410 IAC 15-1.6-2, Emergency services, Indiana Hospital Licensure Rules.</p> <p>QA: cloughlin 11/01/13</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE